

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

May 23, 2017

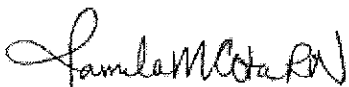
Ms. Angela Zizza, Manager
Valley Terrace
2820 Christian Street
White River Junction, VT 05001-9822

Dear Ms. Zizza:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on April 26, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/26/2017
NAME OF PROVIDER OR SUPPLIER VALLEY TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced, onsite investigation of a self reported event was conducted by the Division of Licensing and Protection on 4/26/2017. One state regulatory violation was identified. The details are listed below:	R100		
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and medical record reviews, the home failed to assure that 1 of 2 residents in the sample (Resident #1) was free from sexual abuse. The specifics are detailed below: Per review of the home's internal investigation, staff interview, and record review, Resident #1 was sexually assaulted by an employee of the home. The employee was covering the upstairs wing of the memory care unit on the evening shift of 4/24/2017. Other staff are available for assistance with the 6 residents on that unit, should they be needed. Per interviews on 4/26/17, staff report that they carry phones to reach each other for help. On the evening of 4/24/2017, staff on the memory care unit tried to reach the employee who was responsible for the 6 residents in the upstairs section. When s/he did not respond, downstairs staff went upstairs and found a resident door closed. Upon entering this room, the resident was observed on the bed,	R224	R224 The facility does ensure the well-being and safety of all our residents, and their rights are our utmost top priority. Under no circumstances do we at Valley Terrace tolerate any inappropriate conduct by employees or anyone else on the property or within our control. The Executive Director self-reported the incident immediately to local law enforcement, along with the State of Vermont Division of Licensing and Protection, the State of Vermont Adult Protective Services, the family, the facility physician, and our residents and their families. Our regulation did not fall short of the required criminal conviction screening along with the adult and child abuse registry check on this certain employee and all prospective employees for that matter. Our Human Resources department screens each and every employee thoroughly before we hire including reference checks.	4/24/17 4/25/17

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Angela M. Zyzanski

TITLE

Executive Director

(X6) DATE

5/22/17

STATE FORM

6899

X4FU11

If continuation sheet 1 of 2

R224 POC accepted 5/22/17 GEDMAN/PN/PMC/WRN

Division of Licensing and Protection

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R224	Continued From page 1 not fully clothed. The employee was observed in the bathroom, adjusting their own clothing. Staff confirm this both in written statements and during interviews on 4/26/2017. In a hand written document dated 4/24/2017 and signed by the employee, s/he confessed to having had sexual relations with Resident #1. This is confirmed by the Director of the home during interview on 4/26/2017.		R224	<p>Under the responsibility of the Health Services Director, the nursing staff have been working on monitored assignments to have additional employees scheduled on the unit where the incident occurred. The Executive Director has limited the scheduling of male employees on that particular unit.</p> <p>The Executive Director has added another educational course for all staff to the Valley Terrace curriculum on Protecting Residents Rights in Assisted Living Facilities.</p> <p>After a thorough investigation by the State Division of Licensing and Protection by two nurse surveyor's the Executive Director asked if there was anything more that we could have done to prevent this incident and the reply was "no, you just couldn't have known".</p>	<p>4/25/17</p> <p>5/1/17</p>